MDR Tracking Number: M5-05-1194-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on 12-20-04.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

The manual muscle testing with report, total evaluation of body excluding hands, level III office visit, chiropractic manipulative treatment spinal 1-2 regions, mechanical traction, manual therapy technique, therapeutic exercises and electrical stimulation unattended from 2-17-04 through 5-16-04 **were found** to be medically necessary. The manual muscle testing with report, total evaluation of body excluding hands, level III office visit, chiropractic manipulative treatment spinal 1-2 regions, mechanical traction, manual therapy technique, therapeutic exercises and electrical stimulation unattended from 5-17-04 through 7-30-04 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

Based on review of the disputed issues within the request, the Medical Review Division has determined that medical necessity issues were not the only issues involved in the medical dispute to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On 1-19-05 the Medical Review Division submitted a Notice to the requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

Per Rule 134.202(d), reimbursement shall be the least of the (1) MAR amount as established by this rule or, (2) the health care provider's usual and customary charge.

CPT code 98940 on 2-16-04, 2-26-04, 3-1-04, 3-16-04, 3-17-04, was denied as "F" "U737" – This charge will be reevaluated upon receipt of the proper procedure code/modifier combination or report justifying medical necessity. Ingenix Encoder Pro shows that this is a valid Medicare code. In accordance with Rule 133.307 (g)(3)(A-F), the requestor submitted relevant information to support delivery of service and the carrier did not reimburse partial payment or give a rationale for not doing so. **Recommend reimbursement of $168.05 ($33.61 x 5 DOS).**

CPT code 98940 on 2-18-04 was denied as "N" "X322" – Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge. The requestor submitted relevant information to support the chiropractic manipulative treatment billed. **Recommend reimbursement of $33.61.**

CPT code 97140-59 on 2-19-04, 2-24-04, 2-26-04, 3-1-04, 3-9-04, 3-10-04, 3-16-04 and 3-18-04, was denied as "N" "X322" - Documentation to substantiate this charge was not submitted or is insufficient to accurately review this charge. The requestor submitted relevant information to support the chiropractic manipulative treatment billed. **Recommend reimbursement of $273.04 ($34.13 x 8 DOS).**

CPT code 97140-59 on 3-2-04 and 3-19-04 was denied as "G" "U687" – This procedure is mutually exclusive to another procedure on the same date. Per rule 133.304 (c) and 134.202(a)(4) carrier didn't specify which service this was mutually exclusive to. **Recommend reimbursement of $68.26 ($34.13 X 2 DOS).**

CPT codes 97545-WH and 97546-H on 3-18-04 and 3-19-04 were reimbursed by the carrier as evidenced by a copy of check #09852691. These services will not be a part of this review.

The carrier denied CPT Code 99080-73 with a "V for unnecessary medical treatment, however, the TWCC-73 is a required report and is not subject to an IRO review per Rule 129.5. The Medical Review Division has jurisdiction in this matter and, therefore, recommends reimbursement. Requestor submitted relevant information to support delivery of service. **Recommend reimbursement of $15.00.**

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the Respondent to pay the unpaid medical fees outlined above as follows:

- In accordance with Medicare program reimbursement methodologies for dates of service on or after August 1, 2003 per Commission Rule 134.202 (c);
- plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this Order.

This Order is applicable to dates of service 2-16-04 through 7-29-04 as outlined above in this dispute.

This Decision and Order is hereby issued this 18th day of March 2005.

Donna Auby
Medical Dispute Resolution Officer
Medical Review Division

DA/da

Enclosure: IRO decision

Envoy Medical Systems, LP
1726 Cricket Hollow
Austin, Texas 78758
Fax 512/491-5145

IRO Certificate #4599

NOTICE OF INDEPENDENT REVIEW DECISION

February 11, 2005

Re: IRO Case # M5-05-1194-01

Texas Worker's Compensation Commission:

Envoy Medical Systems, LP (Envoy) has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to Envoy for an independent review. Envoy has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, Envoy received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a Doctor of Chiropractic, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to Envoy for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the Envoy reviewer who reviewed this case, based on the medical records provided, is as follows:

<u>Medical Information Reviewed</u>

1. Table of disputed service
2. Explanation of benefits
3. Report Dr. Robinson 3/20/04
4. Review Dr. Sage 7/6/04

5. Pre-authorization for Smartwave unit 5/27/04
6. Report Dr. Armstrong 4/30/04
7. TWCC work status reports
8. Reports Dr. Shaw, 4/5/04, 4/26/04, 5/10/04, 5/13/04
9. FCE 4/30/04
10. Reports of Concentra 1/21/04, 1/22/04
11. Report Dr. Peterson 1/4/05
12. RME, TWCC-69 11/10/04
13. Report 9/10/04
14. Report Dr. Eaton 3/15/04
15. SOAP notes Dr. Subia
16. Lumbar ROM report 3/2/04

History

The patient injured his lower back and hip in ___ when he slipped and fell. Numerous medical evaluations, an MRI and electrodiagostic tests were performed. The patient has been treated with medication, lumbar epidural steroid injections, physical therapy and chiropractic treatment

Requested Service(s)

Manual muscle testing w/report, total evaluation of body excluding hands, level III office visit, chiropractic manipulative treatment spinal 1-2 regions, mechanical traction, manual therapy technique, therapeutic exercises, electrical stimulation unattended 2/17/04 – 7/30/04

Decision

I agree with the carrier's decision to deny the requested services after 5/16/04, and I disagree with the decision to deny treatment through 5/16/04.

Rationale

The patient received extensive long-term treatment from his D.C. without relief of symptoms and with only minimal improved function. On 5/17/04 the patient's VAS was 7 on a scale of 10, after three months of care. A trial of conservative care is medically appropriate, and the standard length of treatment for a lumbar sprain/strain with complications of degenerative disk disease is 12-16 weeks. As of 7/6/04 the patient had received around 71 sessions of therapy, which exceeds generally accepted practice guidelines.
Treatment trough 5/16/04 would be reasonable and necessary for the patient's injury. The patient's response to treatment was poor, and should have been discontinued after 5/16/04. Treatment after 5/16/04 was over utilized, inappropriate and failed to be beneficial to the patient. The continued use of failed conservative therapy does not establish a medical rationale for additional non-effective therapy.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.

_____

Daniel Y. Chin, for GP